I , ___________________________________, of the following address:
PATIENT NAME

No./Street: ___________________________ **Apt:**_________

City/Province:_______________________ **Postal Code:** _________

Phone: ____________________ **Email:** _________________________

hereby authorize the release my personal dental records listed below
to the office of

Dr. Kevin Rattray & Associates

located at the following mailing addresses:

☐ 208-1580 Merivale Road
Ottawa, On K2G 4B5
(613) 224-7885
Fax (613) 224-8920
merivale@rattraydentistry.com

☐ 206-900 Greenbank Road
Ottawa, On K2J 1S8
613-825-4241
Fax (613) 825-6557
barrhaven@rattraydentistry.com

- ❑ Recent, dated orodental history
- ❑ Most recent set periodontal probings/PSR
- ❑ Radiographs
  - ❑ bitewings and/or periapicals within the last 2 years
  - ❑ panoramics within the last 5 years
  - ❑ specific, dated radiographs of the area: ___________
- ❑ Any/all specific history of the area: ____________

Patient signature: ______________________________ Date: _____________________